surgery is desirable but was outside the scope of our study, and can only be obtained by means of a carefully designed prospective and randomized trial.

In other words, our study does not provide information regarding the incidence of surgical complications of ASD devices, but hopefully increases the reader’s awareness that potentially disastrous complications can occur even years after device closure, and that surgery for these complications is associated with significant mortality.

We also noted with interest Dr Schachner’s experience with 7 dislocated ASD devices which were successfully removed endoscopically, and congratulate him for these results. Most patients in our study were approached via median sternotomy, which was judged safer especially when hemodynamic instability was present, e.g., in patients presenting with cardiovascular collapse or cardiac tamponade. Given Dr Schachner’s significant experience with dislocated ASD devices, it would be of interest to know the number of percutaneous ASD closures in his institution, the incidence of related surgical complications, as well as whether, during the same time period, he encountered other ASD device complications causing hemodynamic instability, which may have necessitated treatment via sternotomy.

References


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Letter to the Editor

Comparison of a minimized perfusion circuit versus conventional cardiopulmonary bypass

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I read with interest the article by El-Essawi and co-workers [1] on the comparison between a minimized perfusion circuit (MPC) versus conventional cardiopulmonary bypass (CCPB). There is little doubt that novel strategies aiming to reduce the systemic inflammatory response (SIR) induced by CPB should be sought. Whether MPC is such a strategy remains a point of controversy, and while the article presented by El-Essawi and co-workers seems encouraging, a comparison between their groups is difficult. It has been established that field-aspirated blood may increase the incidence of the thrombotic, bleeding and inflammatory complications of CPB [2]. I believe that the discrepancy in the use of a cell-saver device between the groups of patients challenges the robustness of the presented data and their interpretation, as the amplitude of the observed SIR may differ independently of the perfusion strategy used. The fact that a cell-saver device was used in only two patients in the CCPB group, while over 30% of patients in the MPC group had their field-aspirated blood washed, centrifuged and re-transfused may have contributed to the benefits observed in the MPC group. Nevertheless, the authors should be congratulated on their excellent results, and the clear demonstration of the safety and efficacy of their MPC setup.

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Reply to the Letter to the Editor

Reply to Gasparovic

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Keywords: Minimised perfusion circuit; Cardiopulmonary bypass; Pericardiotomy suction

On behalf of my co-investigators, I would like to thank Dr Gasparovic for his comments [1] on our study [2]. The impact of cardiotomy suction on the inflammatory response to cardiopulmonary bypass has been often described. Westerberg et al. [3] even demonstrated a drop in systemic vascular resistance in response to re-transfusion of pericardiotomy suction blood. Nevertheless, most prospective randomised studies comparing conventional heart lung machines with pericardiotomy suction to minimised perfusion circuits (MPCs) without pericardiotomy suction have failed to demonstrate a difference in clinical outcome, some even failing to show benefits in terms of transfusion...